MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00872

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, institution, or street address where death occurred:
Wash. Co. Home
How long in hospital or institution? 16 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Wash Co. Home
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William H. Abrine

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 79 | Months — | Days — | If less than one day ..... hrs. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden name "
15. Birthplace "

16. Informant Mrs. Fred Long
Address Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 12-1945 (month) (day) (year)
Cemetery or crematory Wash Co Home
Location Hagerstown Md

18. Funeral director Scott F. Minnick & Son
Address Hagerstown Md

19. Jan 12 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1945; at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1943 to Jan 11 1945
and that I last saw h. alive on Jan 10 1945

Immediate cause of death	DURATION
Mitral Stenosis	2 yrs +
Due to	
Due to Pulmonary Oedema	24 hrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... injured at work?

23. SIGNATURE Ernest F Cole M.D.
M. D. or other
Address Hagerstown Md Date signed 1/11/45

VS A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (105)

00873

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:
County Washington
City or town Sam Mar
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yrs
Hospital, institution, or street address where death occurred:
Jalurney Memorial Home
How long in hospital or institution? 1 year.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Washington
City or town Sam Mar
(If outside city or town limits, write RURAL and give nearest town)
Street No. Jalurney Memorial Home
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Margait Harnut Albert

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Nathan Albert
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1 - 1860

8. AGE: Years	Months	Days	If less than one day
84	10	26	..... hrs. ..... min.

9. Birthplace Westminster, Md.
(Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name David Bloom
13. Birthplace Md.

MOTHER
14. Maiden name Malinda Price Franklin
15. Birthplace Md.

16. Informant Arthur Albert
Address Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30 - 1945 (month) (day) (year)
Cemetery or crematory Westminster Memetery
Location Westminster Md.

18. Funeral director H H Bankard & Son
Address Westminster, Md.

19. January 27. 1945 John H. Bark
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27, 45 19 ..... at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20 1945 to January 27 1945 and that I last saw h[illegible] alive on January 27 1945

Immediate cause of death	DURATION
Lobar Pneumonia.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE G. W. LeVan M.D.
M. D. or other
Address Boonsboro, Md Date signed 1/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

00874

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one week

Hospital, Institution, or street address where death occurred:

157 South Mulberry

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County

City or town New York City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8823-187thSt. Hollis, Long Island

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME R.E.Lee Allen

3.(b) Social Security Number 231-16-4761

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Elizabeth Allen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6, 1864

8. AGE: Years	Months	Days	If less than one day
80	7	4	..... hrs. ..... min.

9. Birthplace Front Royal, Virginia (Town, county, and state)

10. Usual occupation Supt. Tanning Co.

11. Industry or business J.T.Houck, Tanning Co.

FATHER — 12. Name Branson Allen

13. Birthplace Front Royal, Virginia

MOTHER — 14. Maiden name Not Known

15. Birthplace Not Known

16. Informant Mrs. W. H. Fisher

Address New York City

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 (month) 12 (day) 1945 (year)

Cemetery or crematory Woodbine Cemetery

Location Harrisonburg, Virginia

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Jan. 10. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/9 1945 to 1/10 1945

and that I last saw h.im alive on 1/9 1945

Immediate cause of death	DURATION
Diabetes Mellitus	10yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Ernest F Coe M.D. M. D. or other

Address Hagerstown Md Date signed 1/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:
County: Washington
City or town: Rural - Harpers Ferry, W.Va.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural - Harpers Ferry, W.Va.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sylvanis Marion Ambrose

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 5 1860

8. AGE: Years	Months	Days	If less than one day
84	10	13	..... hrs. ..... min.

9. Birthplace: Clark Co, Va.
(Town, county, and state)

10. Usual occupation: Forman

11. Industry or business: Lime Plant

FATHER
12. Name: Not Known
13. Birthplace: Not Known

MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known

16. Informant: H.C.Ambrose
Address: Engle, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 22 1945 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Charles Town, W.Va.

18. Funeral director: A.F. Eachales.
Address: Bolivar, W.Va.

19. 1/21 19 45 Cornelius N. Castle Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1945, at 8:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15 1944, to Jan. 12, 1945 and that I last saw h[illegible] alive on Jan 12, 1945

Immediate cause of death	DURATION
Arteriosclerosis	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: J.G. Moore M. D. or other
Address: Harpers Ferry, W.Va. Date signed 1/20/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00876

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 years
Hospital, institution, or street address where death occurred:
659 Court Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 659 Court Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Civila M. Anderson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife John W. Anderson
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1862

8. AGE:	Years	Months	Days	If less than one day
	82	4	3	hrs. min.

9. Birthplace Williamsport- Washington- Md.
(Town, county, and state)
10. Usual occupation Home Duties
11. Industry or business

FATHER
12. Name Woltz
13. Birthplace Wash. Co., Md.

MOTHER
14. Maiden name Amelia Wolf
15. Birthplace Wash. Co., Md.

18. Informant Miss Alice Anderson
Address 659 Court Ave.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 1-45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss
Address Hagerstown, Md.

19. Feb. 1. 1945 Chas. H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29, 1945 10:45 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 18 19 45, to Jan 29 19 45
and that I last saw h... alive on Jan 29 19 45

Immediate cause of death	DURATION
Cerebral Thrombosis	10 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. H. Beadle M D. or other
Address Hagerstown Md Date signed Jan 29/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Wm Bradley

Dr Campbell

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

00877

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Security

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years.

Hospital, institution, or street address where death occurred:

103 Green row St.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Security

(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 Green row St

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Sarah Ellen Malinda Biser

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Edward Biser

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 18. 1866

8. AGE: Years	Months	Days	If less than one day
79	0	6	..... hrs. ..... min.

9. Birthplace near Myersville Frd. Co. Md.
(Town, county, and stete)

10. Usual occupation Housewife

11. Industry or business Does Home.

FATHER 12. Name Elias Delauder

13. Birthplace near Myersville

MOTHER 14. Maiden name Malinda Stottlemyer

15. Birthplace near Myersville Frd. Co. Md.

16. Informant Mrs. Lolie Morgan

Address Security Wash. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 28. 1945 (month) (day) (year)

Cemetery or crematory Bakersville Cemetary

Location Bakersville Md.

16. Funeral director Wm J. Bast & Sons

Address Boonsboro Md.

19. Jan 26 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945, at 10 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1945, to Jany 24 1945 and that I last saw h.. alive on Jany 23 1945

Immediate cause of death ..... DURATION

(a) Senility ..... 1 yr.

Due to (b) Cardio-Vascular-Renal Disease ..... 1 yr.

Due to (c) ....

Other conditions ....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. D. Campbell M. D. or other

Address Hagerstown Date signed 1/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00878

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
542 Church Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 629 Church Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Carrie Virginia Brewer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John H. Brewer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 29, 1869

8. AGE: Years	Months	Days	If less than one day
75	9	16	..... hrs. ..... min.

9. Birthplace: Clear Spring- Wash., Md.
(Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business

FATHER
12. Name: John Grosh
13. Birthplace: Wash. Co., Md.

MOTHER
14. Maiden name: Mary Ann Burckley
15. Birthplace: Wash. Co., Md.

16. Informant: John H. Brewer
Address: 542 Church St.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 16, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Snyder-Rowland Funeral Home
Address: Clear Spring, Md.

19. Jan. 16. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 14, 1945 19..... at ..... A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1 - 44 to Jan 14 - 45
and that I last saw him alive on Jan 12 - 45 19.....

	DURATION
Immediate cause of death	
Due to Carcinoma	2 mos
Due to Stomach	
Other conditions Diabetes	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Brewer M. D. or other
Address: Hagerstown Md Date signed: 1/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00879

45-F

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
993 Potomac Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 993 Potomac Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ethel F. Burhans

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William H. Burhans
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): April 21, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	22	hrs. min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Frederick Forthman
13. Birthplace: Germany

MOTHER
14. Maiden name: Sarah Kieffer
15. Birthplace: Cearfoss, Maryland

16. Informant: W. H. Burhans
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland
18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Jan. 13. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 12 1945 at 11.45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jany 1 1944, to Jany 12 1945 and that I last saw h... alive on Jany 12 1945

Immediate cause of death	DURATION
Lymphoblastoma	1 Years
Due to Lymphoblastoma (Beginning with right breast)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. B. Campbell M. D. or other
Address: Hagerstown Md. Date signed Jany 13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00880

CERTIFICATE OF DEATH

Reg. Dist. No. 362

1. PLACE OF DEATH:
County: Washington Co.
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 130 W. Bethel St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dennis Burnett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	

6.(b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): Sept. 30, 1944 (c) If alive, give age ~~3 Months old~~ years

8. AGE: Years ~~Still Born~~ | Months 3 | Days 11 | If less than one day ... hrs. ... min.

9. Birthplace: Hagerstown
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: William Burnett
13. Birthplace: Hagerstown

MOTHER
14. Maiden name: Elizabeth Jennis
15. Birthplace: Mont Royal Pa.

16. Informant: Elizabeth Burnett
Address: 130 W. Bethel St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 12, 45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.

18. Funeral director: William H. Downey
Address: 291 Frederick St.

19. Jan. 12 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 11 1945, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945, to Jan 11 1945
and that I last saw h... alive on Jan 10 1945

Immediate cause of death	DURATION
Bronchial Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: B. Brother M. D. or other
Address: Hagerstown, Md. Date signed: 1/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-B)

00881

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: (WITHIN CORPORATE LIMITS OF) Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred:
428 Cook Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: (WITHIN CORPORATE LIMITS OF) Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 428 Cook Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Malissa S. Carroll

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George W. Carroll
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 4, 1889

8. AGE:	Years	Months	Days	If less than one day
	55	7	29	hrs. min.

9. Birthplace: Tomahawk- Berkley- W. Va.
(Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business

FATHER
12. Name: Isaac Snyder
13. Birthplace: Berkley Co. W. Va.

MOTHER
14. Maiden name: Henrietta Snyder
15. Birthplace: Berkley Co. W. Va.

16. Informant: Miss Margaret Carroll
Address: 428 Cook St.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 5, 1945 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Jan 5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2, 1945 6:50 A. at H. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 1945 to Jan 2 1945
and that I last saw h alive on Jan 2 1945

Immediate cause of death: Asthma — DURATION: 30 yrs.

Due to:

Due to:

Other conditions: Chronic Bronchitis — 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Beachley M.D.
M. D. or other
Address: Hagerstown Md. Date signed: Jan 5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92C)

00882

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:
619 Potomac Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 Potomac Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rhoda Jane Clements

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife W. Thomas Clements

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 11, 1864

8. AGE:	Years	Months	Days	If less than one day
	80	11	11	..... hrs. ..... min.

9. Birthplace West Alvington of Devon, Eng.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name William T. March

13. Birthplace Kingsbridge, England

MOTHER 14. Maiden name Charlotte Pepperell

15. Birthplace Kingsbridge, England

16. Informant Sydney Clements

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-2-45 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Washington, D.C.

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Feb. 2 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31st 1945 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Jan 31 1945 and that I last saw h[illegible] alive on Jan 27 1945

Immediate cause of death	DURATION
Mitral Insufficiency	2 yrs.
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest F Cook M.D. M. D. or other

Address Hagerstown, Md Date signed 1/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Victor Miller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00883

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
326 North Cleveland Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstwon
(If outside city or town limits, write RURAL and give nearest town)
Street No. 326 N. Cleveland Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Minnie Stewart Cline

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Samuel

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): November 11 1869

8. AGE: Years	Months	Days	If less than one day
75	2	4	..... hrs. ..... min.

9. Birthplace: Bunker Hill Berkley Col W.Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: John M. Stewart
13. Birthplace: Bunker Hill W.Va.

MOTHER
14. Maiden name: Sophronia Seibert
15. Birthplace: Bunker Hill W.Va.

16. Informant: Clarende W. Cline
Address: Hagerstwon Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1.17/45 (month) (day) (year)
Cemetery or crematory: Episcopal Cemetery
Location: Bunker Hill W.Va.

18. Funeral director: Andrew K. Coffman
Address: Hagerstwon Md.

19. Jan. 16. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1945 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1944 to 1/15 1945
and that I last saw h.. alive on 1/14 - 1945

Immediate cause of death	DURATION
Cerebral Hemmrhage	2 days
arterio - sclerosis	13 y
Due to	
Due to	
Other conditions ✓	

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op.

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Victor D. Miller
DR. VICTOR D. MILLER M. D. or other
Address: 131 W. WASHINGTON, ST. HAGERSTOWN, MD. Date signed 1-16-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on FILM No. G 92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Nevenstein

00884

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstwon

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred: 44 North Locust St.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Brunswick

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Lorea Mann Clipp

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

B.(b) Name of husband or wife: Charles

B.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): June 19 1900

8. AGE: Years	Months	Days	If less than one day
44 45	6	24	...hrs. ...min.

9. Birthplace: Lovettsville Page Co. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: Charles G. Mann

13. Birthplace: Lovettsville Va.

MOTHER

14. Maiden name: Anna Mills

15. Birthplace: Rappahannock Va.

16. Informant: Mrs. Goldie Harbaugh

Address: Hagerstwon Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/17/45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstwon Md.

18. Funeral director: ndrew KL Coffman

Address: Hagerstwon Md.

19. Jan 17 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: January 13 1945, at 5.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 1944 to Jan 13 1945

and that I last saw h.e.r. alive on Jan 13 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
with myocardial degeneration	
Due to	
Due to Extreme Obesity	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Aubrey Nevenstein M.D. M. D. or other

Address: Hagerstown Md. Date signed 1/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

00885

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 Years
Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 821 Virginia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Reuben Franklin Cooper

3. (b) Social Security Number: 214-09-1949

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace M. Cooper
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 19, 1880

8. AGE: Years	Months	Days	If less than one day
64	5	9	hrs. min.

9. Birthplace: Chewsville- Wash. Md.
(Town, county, and state)
10. Usual occupation: R. R. Employee
11. Industry or business:

FATHER
12. Name: John Cooper
13. Birthplace: ---------- Md.

MOTHER
14. Maiden name: Sallie Rumberger
15. Birthplace: ---------- Md.

16. Informant: Mrs. Grace M. Cooper
Address: 821 Va. Ave.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Feb. 1-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Jan 31. 1945 (Date rec'd by registrar) Chas. H. Bovert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28-45 19..... at ..... P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/26 19 45 to 1/28 19 45
and that I last saw h.. alive on 1/28 19 45

Immediate cause of death	OURATION
Meningococcus Meningitis	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H. Thornbaker M. D.
M. D. or other
Address: 154 W. Washington St. Date signed: 1/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

06886

CERTIFICATE OF DEATH

Reg. Diat. No. 304

1. PLACE OF DEATH:
County: Washington
City or town: Hancock, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Fulton St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie Elizabeth Corbett

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George W. Corbett
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 27 1876

8. AGE: Years	Months	Days	If less than one day
68	6	16	hrs. min.

9. Birthplace: Oceola Mills, Pa.
(Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business
FATHER 12. Name: James Wilson
13. Birthplace: Oceloa Mills, Pa.
MOTHER 14. Maiden name: Hallie Pasemore
15. Birthplace: Unknown
16. Informant: Miss. Hallie Corbett
Address: Hancock, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 17 1945 (month) (day) (year)
Cemetery or crematory: Catauba Methodist Cemetery
Location: Near Cohill Station Washington, Co.
18. Funeral director: Snyder-Rowland
Address: Hancock, Md.
19. Jan 17 1945 (Date rec'd by registrar) G R Jenkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14 1945 at 5:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1945 to Jan. 14 1945 and that I last saw h.. alive on January 8 1945

Immediate cause of death	DURATION
Encephalitis lethargica	3 mos.
Diabetes mellitus	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none.
Date of op.: none.
Autopsy results: none.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Annie Robert Corbett M. D.
Address: Clearsprng, Md. Date signed: 1/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of cause of death is shown on FILM No. G 9 4 MAY 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00887

Reg. Dist. No. 1-4-306

1. PLACE OF DEATH:

County: Washington.

City or town: Highfield.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Mass. County:

City or town: East Saugus
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 57 Chestnut Street.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II. ✓

3. (a) FULL NAME: Fred L. Currier, Technical Sergeant. ASN 32355444

3. (b) Social Security Number: unknown.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife: Lillian L. Currier.

8.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): April 23, 1908.

8. AGE: Years	Months	Days	If less than one day
36	8	21	...hrs. ...min.

9. Birthplace: Haverhill, Mass. (Town, county, and state)

10. Usual occupation: Soldier.

11. Industry or business: U.S.Army.

FATHER — 12. Name: Ralph L. Currier.

FATHER — 13. Birthplace: Massachusetts.

MOTHER — 14. Maiden name: Dora Munn.

MOTHER — 15. Birthplace: Massachusetts,

16. Informant: Camp Ritchie Records.

Address: Camp Ritchie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 17, 1945 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia.

18. Funeral director: M. L. Creager & Son

Address: Thurmont, Md.

19. Jan. 17, 1945 (Date rec'd by registrar) Local Reg. Geo. W. Ferguson, M.D. Registrar By Blanche S. Eyler

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13 19 45, at 10:P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw him alive on ... 19...

Immediate cause of death	DURATION
Cause to be sent-later	
Due to	
Due to Carbon monoxide poisoning (Accidental) C.W.S.R.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: 1-14-45 & 1-16-45 as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~: to be sent-later Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: J. Robert Wells Deputy Med. Exam. Wash. Co. Md. M. D. or ~~C.M.~~

Address: Hagerstown, Md. Date signed: Jan 16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

00888

Reg. Dist. No. 3021

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years.

Hospital, institution, or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution? 1 mo 20

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 69 W. Franklin St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary E. Curtis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Wilkins Curtis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1874

8. AGE: Years	Months	Days	If less than one day
70	4	21	..... hrs. ..... min.

9. Birthplace ---------- Mississippi (Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

FATHER 12. Name ---------- Wilkinson

13. Birthplace Mississippi

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Claude M. Frye

Address 1800 Walnut Ave- Balto, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 5. 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Jan. 3. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2. 1945 at 7:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938, to Jan 2 1945; and that I last saw h.er alive on Jan 1 1945

Immediate cause of death	DURATION
Chr. bronchial asthma	10yrs
Due to chr. myocarditis	5yrs
Due to Fractured (closed) rt femur	30 da
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Nov. 12'44

Where did injury occur? Hagerstown, (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?) home

Means of injury tripped & fell on floor Injured at work?

23. SIGNATURE L Richard Wells M. D.

DEPUTY MEDICAL EXAM. WASH. CO., MD.

Address Hagerstown, Md. Date signed 1/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Porterfield

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (HED) K ✓

00889

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstwon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Days
Hospital, Institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstwon
(If outside city or town limits, write RURAL and give nearest town)
Street No. 608 Highland Way
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Mintie Elizabeth Dorraugh

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: David
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): August 3 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69	5	12		

9. Birthplace: Middleburg Franklin Co Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: John Byrem
13. Birthplace: Middleburg Pa

MOTHER
14. Maiden name: Ellen Burger
15. Birthplace: Middleburg Pa.

16. Informant: Mrs. Ira Coffman
Address: Hagerstwon Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/18/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstwown Md

19. Jan. 16. 1945 (Date rec'd by registrar) Chas. H. Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1945 at 12.10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 10 1945 to Jan 15 1945 and that I last saw h... alive on Jan 14 1945

Immediate cause of death	DURATION
Intestinal Obstruction	1/10/45
Cardiac failure	1/15/45
Due to Carcinoma Colon	3
Myocarditis Chr.	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: H. S. Porterfield M.D.
M. D. or other
Address: 136 W Washington Date signed 1/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Layman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (96)

00890

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagesrtwon

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 Years

Hospital, Institution, or street address where death occurred:

128 East Antietam St.

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 128 East Antietam St

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Dr. Hugh Bifford Downs

3. (b) Social Security Number 214-05-4 720

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Irene

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 11 1874

8. AGE: Years	Months	Days	If less than one day
69	7	20	..... hrs. ..... min.

9. Birthplace Baltimore Baltimore Co. Md. (Town, county, and state)

10. Usual occupation Pharmacist

11. Industry or business Retired

FATHER 12. Name William Downs

13. Birthplace England

MOTHER 14. Maiden name No Record

15. Birthplace No Record

16. Informant Mrs. Irene Downs

Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/45 (month) (day) (year)

Cemetery or crematory Rest Haven cemetery

Location Hagerstown Md

18. Funeral director Andrew K Coffman

Address Hagerstwin Md

19. Jan. 3. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1945 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1943 to Jan 1 1945 and that I last saw h.. alive on Dec. 24 1944

Immediate cause of death	DURATION
Hemorrhage	
Due to Ruptured	
Aneurysm of Ab Aorta	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Ruptured aneurysm Ab aorta

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. Witherspoon, M.D. M. D. or other

Address Hagerstown, Md. Date signed 1-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

00891

CERTIFICATE OF DEATH

Reg. Diat. No. 304

1. PLACE OF DEATH:
County: Washington
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BENJAMIN FELD

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Marie Feld.
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Nov. 1 - 1881

8. AGE: Years	Months	Days	If less than one day
63	2	0	....hrs. ....min.

9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business
FATHER 12. Name: Not Known
13. Birthplace
MOTHER 14. Maiden name: Not Known
15. Birthplace
16. Informant: Mrs. Maria Moleshky
Address: 4014 Pennhurst ave Baltimore md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4 1945 (month) (day) (year)
Cemetery or crematory: Rose Dale
Location: Baltimore, Md
18. Funeral director: Sol. Levinson & Bro.
Address: 1124 W. North ave Baltimore Md
19. Jan 3 1945 (Date rec'd by registrar) J. B. Jenkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 1945, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 20 1944, to January 1 1945
and that I last saw him alive on December 20 1944

Immediate cause of death	DURATION
Coronary occlusion with acute exacerbation	6 weeks / 1 day
Due to: Hypertensive cardiovascular renal disease	?
Due to:	
Other conditions: Diabetes Mellitus	20 years

(Include pregnancy within 3 months of death)

Major findings of operation: none. Date of op.
Autopsy results: none.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Archie Robert Cohen M. D. or other
Address: Clearspring, Md. Date signed Jan. 2. 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

00892

Reg. Dist. No. 306

1. PLACE OF DEATH:
County Washington
City or town Smithsburg Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Washington
City or town Smithsburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)
2.(a) If veteran, name war none

3. (a) FULL NAME Mrs Mary Lydia Beard Fogle

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: none
6.(c) If alive, give age —
7. Birth date of deceased (mo., day, yr.): 8-1-1865

8. AGE:

Years	Months	Days	If less than one day
79	4	6	— hrs. — min.

9. Birthplace Smithsburg Md (Town, county, and state)
10. Usual occupation Housekeeping
11. Industry or business —

FATHER
12. Name Geo. N. Beard
13. Birthplace Near Smithsburg

MOTHER
14. Maiden name Margaret Lydia
15. Birthplace Smithsburg Md

16. Informant Mrs Maurice Palmer
Address Smithsburg Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof 1-17-1945 (month) (day) (year)
Cemetery or crematory Smithsburg
Location Smithsburg Md

18. Funeral director Geo. B. Hoover
Address Smithsburg Md

19. Jan 16 1945 (Date rec'd by registrar) Geo. W. Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1945 at 7:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/26/44 1944, to 1/14 1945
and that I last saw her alive on 1/14/45 1945

Immediate cause of death Coronary occlusion — DURATION
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results? —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE A. W. Linderman M. D. or other
Address Waynesboro Pa Date signed 1/15/45

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00893

CERTIFICATE OF DEATH

FILM No. G 94 MAY 14 1945

Reg. Dist. No. 303

1. PLACE OF DEATH:

County: Washington

City or town: Rural Clear Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Residence Indian Springs Dist.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Rural Clear Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Indian Springs Dist.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Gehr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Joseph Gehr

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 7 1857

8. AGE: Years	Months	Days	If less than one day
87	11	29	hrs. min.

9. Birthplace: Washington Co.
(Town, county, and state)

10. Usual occupation: Home work

11. Industry or business

FATHER
12. Name: Henry Forsythe
13. Birthplace: Washington Co.

MOTHER
14. Maiden name: Charlett Mina
15. Birthplace: Not Known

16. Informant: Henry Forsythe
Address: 1358 Salem Ave. Hagerstown, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) Jan (day) 9 (year) 1945

Cemetery or crematory: St. Paul's Cemetery

Location: Near Clear Spring, Md. Route 40

18. Funeral director: Snyder-Rowland Funeral Home
Address: Clear Spring, Md.

19. (Date rec'd by registrar) Jan 8 1945 Registrar: Joseph W. Murray

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 1945, at 9P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
acute cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Roland Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D. or other

Address: Hagerstown, Md. Date signed: 1/6/1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. po rterfield

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d) N

00894

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 weeks

Hospital, institution, or street address where death occurred:

Hotel Alexander

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstwon R # 1

(If outside city or town limits, write RURAL and give nearest town)

Street No. Trails rnd

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME George Sylvester Goodrich

3.(b) Social Security Number 214-09-5980

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Nancy C.

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) July 17 1882

8. AGE: Years	Months	Days	If less than one day
62	7	14	..... hrs. ..... min.

9. Birthplace Philadelphia Philadelphia Co/ Pa (Town, county, and state)

10. Usual occupation Foreman

11. Industry or business Pangborn Corp

FATHER 12. Name George S. Goodrich

13. Birthplace Baltimore Md.

MOTHER 14. Maiden name Mary McCarthy

15. Birthplace Philadelphia Pa.

16. Informant Mrs. Nancy C. Goodrich

Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/29/45 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstwon Md.

18. Funeral director Andrew K. Coffman

Address Hagerstwon Md.

19. Jan 28. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1945 at 8 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug. 10 1945 to Jan 26 1945 and that I last saw h.. alive on Jan 26 1945

	DURATION
Immediate cause of death: Carcinoma Rt. Lung	P.
Due to: Cardiac failure	11/26/45
Due to:	
Other conditions: Tuberculosis both Kidneys & Bladder	? 5

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. L. Porterfield M.D. M. D. or other

Address 136 W Washington Date signed 1/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Hornbaker

Evidence for change of cause of death is shown on FILM No. G 9 4 APR 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

00895

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstwon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Hours
Hospital, institution, or street address where death occurred:
Washinton County Hospital
How long in hospital or institution? 3 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 645 Brown Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Samuel Elgin Gordon

3.(b) Social Security Number: 705-10-6786

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Daisy
8.(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): July 11 1888
8. AGE: Years: 56 Months: 6 Days: 16 If less than one day: hrs. min.
9. Birthplace: Middletown Berkley Co. W. Va. (Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: W.M.R.R.
FATHER 12. Name: Samuel Gordon
FATHER 13. Birthplace: Martinsburg W. Va.
MOTHER 14. Maiden name: Sarah Edmondson
MOTHER 15. Birthplace: Middletown Va.
16. Informant: Mrs. Daisy Gordon
Address: Hagerstwon Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/30/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Jan 30 1945 (Date rec'd by registrar) Chas H Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27 1945 19 at 5 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/12 1942 to 1/27 1945 and that I last saw h... alive on 1/27 1945

	DURATION
Immediate cause of death: Pulmonary Hemorrhage; due to Lung abscess	15 months
Due to: not due to tuberculosis c.w.b.R.	about 6 weeks.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John W Hornbaker M. D.
Address: 64 W. Washington St. M. D. or other
Date signed: 1/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

00896

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
4 South Cannon Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 South Cannon Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles H. Gray

3.(b) Social Security Number: 214-09-1214

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single ~~Divorced~~

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 28, 1897

8. AGE: Years	Months	Days	If less than one day
47	11	19	hrs. min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Electric Welder
11. Industry or business: Fairchild Aircraft

FATHER
12. Name: Lewis F. Gray
13. Birthplace: Hagerstown, Maryland

MOTHER
14. Maiden name: Helen J. Heil
15. Birthplace: Hagerstown, Maryland

16. Informant: Lewis F. Gray
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-19-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Jan. 18. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16, 19 45, at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to ..., 19...
and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
chr. myocarditis	2yrs
Due to: acute ventricular fibrillation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

DEPUTY MEDICAL EXAM. WASH. CO., MD.

23. SIGNATURE: S. Robertson Wells M. D.
Address: Hagerstown, Md. Date signed: 1/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2 X

00897

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington (IF IN CORPORATE LIMITS)
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
239 E. Baltimore Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington (IF IN CORPORATE LIMITS)
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 239 E. Balto. Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Maud Odessa Green

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Arthur B. Green
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 27, 1882

8. AGE: Years	Months	Days	If less than one day
62	4	14	..... hrs. ..... min.

9. Birthplace Myersville- Fredk. Co., Md. (Town, county, and state)
10. Usual occupation Home Duties
11. Industry or business

MOTHER FATHER
12. Name Josiah Poffenberger
13. Birthplace Fredk. Co., Md.
MOTHER
14. Maiden name Maria Renner
15. Birthplace Fredk. Co., Md.

16. Informant Arthur B. Green
Address 239 E. Balto. St. Hagertown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 13-45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagertown, Md.

18. Funeral director Fred W. Kraiss
Address Hagerstown, Md.

19. Jan. 12, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10, 1945 10:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1944 to Jan. 10, 1945 and that I last saw h[illegible] alive on Jan. 9, 1945

Immediate cause of death	DURATION
Carcinoma of Colon	
& Liver	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma Ascending Colon obstructed. Date of op 1-6-44

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. Howard George M. D. or other
Address Hagerstown, Md. Date signed 1-10-45

Dr. Campbell

00898

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 162-6

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Washington
City or town Hagerstwon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, institution, or street address where death occurred:
855 Dewey Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 855 Dewey Ave
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME Mrs. Jane Hubbs Grubbs

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife George

6.(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) September 25 1864

8. AGE: Years	Months	Days	If less than one day
80	3	26	..... hrs. ..... min.

9. Birthplace Forrest Mills Fred. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER
12. Name John Hubbs
13. Birthplace Bethesda Md.

MOTHER
14. Maiden name Priscilla Hubbs
15. Birthplace Bethesda Md.

16. Informant Mr. Frank Weible
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/23/45 (month) (day) (year)
Cemetery or crematory Kemptown Cemetery
Location Kemptown Md.

18. Funeral director Andrew K. Coffman
Address Hagerstwon Md.

19. Jan 22, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1945 at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Janu 13 1945 to Janu 21 1945 and that I last saw h 22 alive on Janu 21 1945

Immediate cause of death	DURATION
d Paralytic	
No further information Cem. & R.	
Due to	
Due to	
Other conditions	
(Include pregnancy within 3 months of death)	

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. B. Campbell M. D. or other
Address Hagerstown Md Date signed Janu 23 1945

Dr. Hornbaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00899

Reg. Diat. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstwon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Days
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstwon
(If outside city or town limits, write RURAL and give nearest town)
Street No. 61 est franklin St
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Mrs. Edna May Harper

3.(b) Social Security Number 705-10-6211

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife Ray
6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) May 10 1897

8. AGE: Years	Months	Days	If less than one day
47	8	7	hrs. min.

9. Birthplace Hagerstown ash. Co. Md.
(Town, county, and state)
10. Usual occupation Telephone Operaror
11. Industry or business W.M.R.R.

FATHER
12. Name John S. Welsh
13. Birthplace Funkstown Md.

MOTHER
14. Maiden name Nettie M. Boward
15. Birthplace Hagerstwon Md.

16. Informant Robert R. Harper
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20/45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstwon Md.

18. Funeral director Andrew K. Coffman
Address Hagerstwon Md.

19. Jan 20. 1945 (Date rec'd by registrar) Ghent H. Barnett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1945 19 at 2.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-2 19 41, to 1-17 — 1945
and that I last saw h... alive on 1-17-45 19

Immediate cause of death	DURATION
Pulmonary embolism	20 hours
Due to Venous Thrombosis (iliacs + inf. V. cava) Unknown	
Due to	
Other conditions Coronary occlusion	4 mo.

(Include pregnancy within 3 months of death)

Major findings of operations Same as outlined above
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John N Hornbaker M.D.
M. D. or other
Address 154 W. Washington St. Date signed 1-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

00900

CERTIFICATE OF DEATH

Reg. Diat. No. 307

1. PLACE OF DEATH:
County: Washington
City or town: Garrotts Mill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Garrotts Mill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Helen Rebecca Harris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 20 1944

8. AGE: Years | Months: 4 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Garrotts Mills Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Alvin W Harris
13. Birthplace: Garrotts Mills Md

MOTHER
14. Maiden name: Mary M. Brown
15. Birthplace: Garrotts Mills Md

16. Informant: Alvin W Harris
Address: #1 RFD Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 9-45 (month) (day) (year)
Cemetery or crematory: Mt Marion Baptist
Location: Garrotts Mills Washn Co Md

16. Funeral director: C Robert Weber
Address: Brunswick Md

19. Jan 7 19 45 (Date rec'd by registrar) Cornelius D Castle Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1945 at 4.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to Jan 6 1945 and that I last saw her alive on Jan 6 1945

Immediate cause of death	DURATION
Bronchio-Pneumonia.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. W. Lilton M. D.
M. D. or other
Address: Boonsboro Date signed: 1/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Miller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

00901

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years

Hospital, institution, or street address where death occurred: 266 Hager St.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 266 Hager st

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Clinton William Hartle

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mazie

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): June 1 1859

8. AGE: Years	Months	Days	If less than one day
85	7	12	hrs. min.

9. Birthplace: Leitersburg Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER — 12. Name: Jacob Hartle

13. Birthplace: Leitersburg Md.

MOTHER — 14. Maiden name: Amantha Creager

15. Birthplace: Leitersburg Md.

16. Informant: Chester W. Hartle

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/45 (month) (day) (year)

Cemetery or crematory: Rose Hill cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Jan 16, 45 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1945 at 330 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/20 1944, to 1/13 1945 and that I last saw h... alive on 1/12 1945

Immediate cause of death	DURATION
Uraemia —	
Chronic Endocarditis.	3 days
Chronic Prostatitis.	2
Due to: arteric-Sclerosis.	2
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Victor D. Miller

DR. VICTOR D. MILLER, M. D. or other

Address: 131 W. WASHINGTON, ST. HAGERSTOWN, MD. Date signed: 1/13/1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00902

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, Institution, or street address where death occurred:
38 Fairground Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 38 Fairground Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Cora B. Hemmehuyer

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife Albertis Hemmehuyer
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17 - 1870

8. AGE: Years	Months	Days	If less than one day
74	8	23	hrs. min.

9. Birthplace Chewsville Washington Md
(Town, county, and state)
10. Usual occupation Home Duties
11. Industry or business Own home
FATHER 12. Name Silas Beard
13. Birthplace Chewsville Md
MOTHER 14. Maiden name Clara Martin
15. Birthplace Chewsville Md
18. Informant Mr. Alfred Hemmehuyer
Address Hagerstown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 13-1945 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Hagerstown Md
18. Funeral director Scott F. Minnich Son
Address Hagerstown Md
19. Jan. 12 1945 Chas H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1945, at 9.45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1945, to Jan 10 1945
and that I last saw h[illegible] alive on Jan 10 1945

Immediate cause of death	DURATION
Cardiac dilatation	
Due to Chronic myocarditis	
Due to Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. F. Rathe M. D. or Other
Address Hagerstown Date signed 1/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00903 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: 922 Corbett Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Washington
WITHIN CORPORATE LIMITS
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
Street No. 922 Corbett Street (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Dosha M. Holton

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Charles Holton 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1876

8. AGE: Years	Months	Days	If less than one day
68	8	24	hrs. min.

9. Birthplace ---------- Virginia (Town, county, and state)
10. Usual occupation Home Duties
11. Industry or business

FATHER
12. Name Benjamin Caldwell
13. Birthplace ---------- Va.

MOTHER
14. Maiden name Catherine Ridenour
15. Birthplace ---------- Virginia

16. Informant Mrs. Edward Alexander
Address 922 Corbett Street- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 2-45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss
Address Hagerstown, Md.

19. Feb. 1. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30-45 19 at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1944 to Jan 30 1945 and that I last saw h 21 alive on Jan 30 1945

	DURATION
Immediate cause of death Carcinoma Gallbladder	3
metastasis to liver	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H B Porterfield M D M. D. or other
Address 134 W Washington Date signed 1/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Binkley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72-2

00984

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Years

Hospital, institution, or street address where death occurred: Maugansville Road

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Maugansville Road
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Samuel Walter Johnston

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nettie Jones

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): May 23 1877

8. AGE: Years	Months	Days	If less than one day
67	7	28	..... hrs. ..... min.

9. Birthplace: Waynesboro Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation: Contractor

11. Industry or business: Heating & Plumbing

FATHER
12. Name: Samuel Johnston
13. Birthplace: Waynesboro Pa.

MOTHER
14. Maiden name: Annabel Wills
15. Birthplace: Emmitsburg Md.

16. Informant: Mrs. S. Walter Johnston
Address: Maugansville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/14/45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md

19. Jan 13. 45 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11 1945 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1945 to Jan 11 1945 and that I last saw him alive on Jan 11 1945

Immediate cause of death	DURATION
Coronary Thrombosis	18 Hrs
Due to	
Due to Previous attack of Coronary Thrombosis, 9/10/42	
Other conditions Chr Endocarditis & Myocarditis ?	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: O. H. Binkley M.D. M. D. or other

Address: Hagerstown, Md. Date signed 1/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0905

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 69-3-10
Hospital, Institution, or street address where death occurred:
121 W Antietam St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wash.
City or town: Hagerstown
(If ontside city or town limits, write RURAL and give nearest town)
Street No.: 121 W Antietam
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Eliason J. Keefer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Bessie E. Keefer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 24, 1876

8. AGE: Years	Months	Days	If less than one day
68	3	10	hrs. min.

9. Birthplace: Indian Springs, Wash. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Retired

FATHER
12. Name: Adam Keefer
13. Birthplace: Indian Springs Md.

MOTHER
14. Maiden name: Elizabeth Cassidy
15. Birthplace: Indian Springs Md

16. Informant: Mrs Robert Foltz
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 6 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown Md.
18. Funeral director: Leo J Minnich & Son
Address: Hagerstown Md.

19. Jan. 6. 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 4 1945, at 5:A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 1943 19.. to Jan 4 1945
and that I last saw h.. alive on Dec 8th 1944

Immediate cause of death	DURATION
Chronic Myocarditis	
Arteriosclerosis	
Due to: Cardiac Decompensation	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B Brather M. D. or other
Address: Hagerstown Date signed: 1/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

Dr. Layman

00906

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Years

Hospital, Institution, or street address where death occurred:

121 Elizabeth St.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 121 Elizabeth St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Jemeta Henry Knight

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): January 4 1857

8. AGE: Years	Months	Days	If less than one day
88	-	4	....hrs. ....min.

9. Birthplace: Luray Page Co. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: John Henry

13. Birthplace: Luray Va.

MOTHER — 14. Maiden name: Delilah Price

15. Birthplace: Luray Va.

16. Informant: Mrs. Mary Smeadley

Address: Hagerstown Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1/10/45 (month) (day) (year)

Cemetery or crematory: Ever Green Cemetery

Location: Luray Va.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Jan. 9, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8 1945, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 43, to Dec. 7 1944

and that I last saw her alive on 1945

Immediate cause of death	DURATION
Myocardial Insuf., chronic	
Due to Nephritis, chronic	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: W. Walter Layman M.D. M. D. or other

Address: Hagerstown, Md. Date signed 1-8-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

00987

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:
County WASHINGTON
City or town HANCOCK MD.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: R-F-D # 1
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(Former, born infants give residence of mother)
State MARYLAND County WASH
City or town HANCOCK Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R F D # 1
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME ELVINA MAY LANDERS.

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 12 1878

8. AGE: Years 66 | Months 4 | Days 25 | If less than one day ____ hrs. ____ min.

9. Birthplace WASH Co MD. (Town, county, and state)

10. Usual occupation CHICKEN FARM

11. Industry or business RAISING CHICKENS

FATHER 12. Name JOSEPH LANDERS

13. Birthplace ENGLAND.

MOTHER 14. Maiden name MARY MENDAL.

15. Birthplace PHILADELPHIA PA

16. Informant ARTHUR R LANDERS

Address HANCOCK MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JAN 10 1945 (month) (day) (year)

Cemetery or crematory PRESBYTERIAN.

Location HANCOCK MD.

18. Funeral director I. P. JENKINS.

Address HANCOCK MD

19. JAN 8 1945 (Date rec'd by registrar) I R Jenkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1944 to Jan. 7 1945 and that I last saw h alive on Sept. 14 1944

Immediate cause of death	DURATION
Coronary occlusion.	
Acute arteriosclerotic	1 mo.
Due to Hypertensive Cardio	
vascular renal disease	15 years
Due to	
Other conditions None.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None.
Of autopsy None.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Archie Robert Cohen M. D. or other
Address Clearspring Md. Date signed 1/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00968

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, institution, or street address where death occurred:
414 Guilford Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
Street No. 414 Gulliford Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alice Jane Lumm

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Harry I. Lumm
6.(c) If alive, give age 35 years
7. Birth date of deceased (mo., day, yr.) Feb 20 1910

8. AGE: Years	Months	Days	If less than one day
34	11	2	hrs. min.

9. Birthplace Charlton Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business home

FATHER 12. Name David Albert Gossard
13. Birthplace Welsh Run Pa.

MOTHER 14. Maiden name Grace Curfman
15. Birthplace Md.

16. Informant Grace Curfman
Address Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25 1945 (month) (day) (year)
Cemetery or crematory Rest Haven Cem
Location Hagerstown Md

18. Funeral director Edith V. Leaf
Address Williamsport Md

19. Jan 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1945, at 1.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1940, to Jan. 22 1945 and that I last saw h-er alive on Jan. 21 1945

	DURATION
Immediate cause of death	
Cerebral Congestion (Apoplexy)	4 hours
Due to	
Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Charles Bagby M.D. Baltimore Date of op. Oct 40 and May 44

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Williamsport Md Date signed 1/22/45

Evidence for change of age of deceased is shown on FILM No. G 93 MAR 20 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

00989

Reg. Dist. No. X 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Washington Co. Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Washington
City or town: Hagerstown Rt. 4 Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: none
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Gertrude May Edwards Massie

3.(b) Social Security Number: none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: none
6.(c) If alive, give age: — years
7. Birth date of deceased (Mo., day, yr.): Jan 31 1871

8. AGE: Years	Months	Days	If less than one day
73 72	5	28	— hrs. — min.

9. Birthplace: Smithsburg Md (Town, county, and state)
10. Usual occupation: Home Keeping
11. Industry or business: none

FATHER
12. Name: Harry Edwards
13. Birthplace: New York State

MOTHER
14. Maiden name: Minnie Kahler
15. Birthplace: Ringgold Md

16. Informant: Stafford Massie
Address: Hagerstown Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof 1-31-1945 (month) (day) (year)
Cemetery or crematory: Smithsburg
Location: Smithsburg Washington Co Md

18. Funeral director: Geo. B. Hoover
Address: Smithsburg Md

19. Jan 30 1945 (Date rec'd by registrar) J. Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 29 1945 at 4-05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 1945, to Jan 29 1945 and that I last saw h... alive on Jan 29 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Arteriosclerosis	10 yrs
Due to:	
Other conditions: Chronic Nephritis	6 yrs

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: G. C. Kahler M. D. or other
Address: Smithsburg Date signed: 1/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3Fa)

CERTIFICATE OF DEATH

00910

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years

Hospital, Institution, or street address where death occurred:

29 N. Locust Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 29 N. Locust Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Samuel L. McAfee

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10, 1890

8. AGE: Years	Months	Days	If less than one day
54	7	26	..... hrs. ..... min.

9. Birthplace: Washington County, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

MOTHER FATHER

12. Name: Samuel McAfee

13. Birthplace: Wash. Co., Md.

14. Maiden name: Alberta L. Slick

15. Birthplace: Wash. Co., Md.

16. Informant: Raymond M. McAfee

Address: 29 N. Locust Street- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 9-45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Jany. 9 19 45 Chas H Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 5, 1945 10:45 A. M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 19 45 to Jan 5 1945

and that I last saw him alive on Jan 5 1945

Immediate cause of death: Arterio-sclerosis Chronic Nephritis — DURATION: ?

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Victor D. Miller M. D. or other

DR. VICTOR D. MILLER

131 W. WASHINGTON, ST.

Address: HAGERSTOWN, MD. Date signed 1/6 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

00911

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
17 Winter Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 17 Winter Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ellen Stull McClain

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Daniel S. McClain

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 5, 1878

8. AGE: Years	Months	Days	If less than one day
66	5	14	....hrs. ....min.

9. Birthplace: Hagerstown, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Lushbaugh
13. Birthplace: Hagerstown, Maryland

MOTHER
14. Maiden name: M. Catherine McGrath
15. Birthplace: Chambersburg, Pa.

16. Informant: Jeannette V. McClain
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-21-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Jan. 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19 1945 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 15 1945, to Jan 19 1945

and that I last saw h-er alive on Jan 18 1945

Immediate cause of death	DURATION
Bronchitis	
Due to Paresis, acute coronary	
Due to Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Ellen Lamneck M.D
M. D. or other

Address: Hagerstown Md Date signed 1/19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

00912

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? unknown
Hospital, institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? unknown

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pa County
City or town Lancaster
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war World War I ✓

3.(a) FULL NAME Archibald B. McDowell

3.(b) Social Security Number 066-3-4317

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 4 1898

8. AGE: Years 46 | Months 8 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Lancaster Pa (Town, county, and state)

10. Usual occupation clerk

11. Industry or business Fairchild aircraft

FATHER 12. Name Robert L. McDowell

13. Birthplace Lancaster Pa

MOTHER 14. Maiden name Rebecca J Gillian

15. Birthplace Fort Louden Pa

16. Informant D J Lininger

Address Mercersburg Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31 1945 (month) (day) (year)

Cemetery or crematory Spring Grove

Location Lancaster Pa

18. Funeral director H E Lininger

Address Mercersburg, Pa.

19. Jan 29 1945 (Date rec'd by registrar) Elbert Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28, 1945 at 4:35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13, 1944, to Jan 28, 1945

and that I last saw him alive on Jan 28, 1945

Immediate cause of death	DURATION
Acute diffuse (glomerulo) nephritis	6 wks.
Due to Acute hepatitis	4 "
Due to	
Other conditions Hypertensive encephalopathy	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R L Stauffer, M.D. M. D. or other

Address Hagerstown, Md Date signed 1/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00913

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown (WITHIN CORPORATE LIMITS OF)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Beaver Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Albert McKee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

9.(b) Name of husband or wife: Margaret E.
9.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 7, 1873

8. AGE: Years	Months	Days	If less than one day
71	3		hrs. min.

9. Birthplace: Washington Co., Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Thomas McKee
13. Birthplace: Washington Co., Md.

MOTHER
14. Maiden name: Elizabeth Fahrney
15. Birthplace: Washington Co., Md.

16. Informant: Mrs. Margaret E. McKee
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 9, 1945 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Md.
18. Funeral director: Lewis F. Reecher L F Reecher
Address: Funkstown, Md.

19. Jan. 8, 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1945, at 9:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24 1944, to Jan 6 1945
and that I last saw h[illegible] alive on Jan 6 1945

Immediate cause of death	DURATION
Pulmonary Infarction	dec 25-44
Due to: Pulmonary artery Thrombosis	
Due to:	
Other conditions: Carcinoma of Bladder	1944

(Include pregnancy within 3 months of death)

Major findings of operations:
Pulmonary Infarct R. Base. Date of op.
Autopsy results: Cancer Bladder
PHYSICIAN: Please underline the cause to which death should be charged statistically.
Thrombosis P. Pulm. artery

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Audrey Rowntree M.D.
M. D. or other
Address: Funkstown Md Date signed 1/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

CERTIFICATE OF DEATH

00914

Reg. Diat. No. 30 2

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 South Potomac Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Waneta A. Meyers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Daniel Meyers

5.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) January 25, 1887

8. AGE: Years	Months	Days	If less than one day
57	11	5	hrs. min.

9. Birthplace Knoxville, Tenn,
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Allison

13. Birthplace Knoxville, Tenn.

MOTHER 14. Maiden name Mary -------

15. Birthplace Knoxville, Tenn.

16. Informant Daniel Meyers

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-23-45 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Jan. 22, 1945 (Date rec'd by registrar) Chas H Boores Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1945, at 1:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29 1944 to Jan 20 1945 and that I last saw h alive on Jan 19 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to Arterio-sclerosis	
Due to Heart disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sidney Hamerstrom M.D.
M. D. or other

Address Hagerstown, Md. Date signed 1/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

0915

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 248 Prospect Ave,

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: George W. Mosser

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 28, 1879.

8. AGE: Years	Months	Days	If less than one day
65	4	22	hrs. min.

9. Birthplace: Mercersburg, Penna. (Town, county, and state)

10. Usual occupation: Live stock dealer

11. Industry or business:

FATHER — 12. Name: John Mosser

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Catherine Kettle

15. Birthplace: Pennsylvania

16. Informant: Florence Mosser (Wife)

Address: 248 Prospect Ave, Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 22, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Greencastle, Penna.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown

19. Jan. 20 1945 Chas. H. Bowers (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1945 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 13 1945 to Jan. 19 1945 and that I last saw him alive on Jan. 18 1945

Immediate cause of death: Coronary Thrombosis — DURATION: 6 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank F. Shupp M.D. M. D. or other

Address: 104½ N. Potomac St Hagerstown Md. Date signed Jan. 19, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on FILM No. G 9 4 MAY 14 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Dr. Wells

00916

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Years
Hospital, Institution, or street address where death occurred:
326 East Franklin Street S
How long in hospital or institution? No

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 326 East Franklin Street
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: William Henry Nally

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): November 19, 1856

8. AGE: Years	Months	Days	If less than one day
~~78~~ 88	2	22	....hrs. ....min.

9. Birthplace: Hagerstown Washington Co. Md.
(Town, county, and state)

10. Usual occupation: Transfer

11. Industry or business

FATHER
12. Name: John H Nally
13. Birthplace: Keedysville, Maryland

MOTHER
14. Maiden name: Susan Roberts
15. Birthplace: Keedysville, Md.

16. Informant: Paul Perry
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 13, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: Andrew K Coffman
Address: Hagerstown, Md.

19. Jan 11 1945 (Date rec'd by registrar) Earl Boerner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11 19 45 at 4 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ....19...., to ....19....
and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Chr. myocarditis	
Due to: acute ventricular fibrillation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No ....Date of op. ....

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury Injured at work?

23. SIGNATURE: E Robert Wells DEPUTY MEDICAL EXM. WASH. CO., MD. M. D.
Address: Hagerstown Md. Date signed: 1/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

00917

Reg. Dist. No. 306

1. PLACE OF DEATH:

County: Washington

City or town: Smithsburg, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Smithsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Samuel D. Newman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Irene H. Newman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 22, 1850

8. AGE: Years: 94 | Months: 5 | Days: 9 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Fairfield, Pa.
(Town, county, and state)

10. Usual occupation: Retired Mail Clerk

11. Industry or business

FATHER
12. Name: Thomas Newman
13. Birthplace: Not Known

MOTHER
14. Maiden name: Mary C. Angel
15. Birthplace: Middleburg, Carroll Co. Md.

16. Informant: Hoy Newman
Address: Smithsburg, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-3-45 (month) (day) (year)

Cemetery or crematory: Smithsburg Cemetery

Location: Smithsburg, Maryland

18. Funeral director: W. H. Downey

Address: Hagerstown, Maryland

19. Feb 2 1945 (Date rec'd by registrar) Geo. W. Ferguson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1945, at 3.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1943, to Jan 31 1945 and that I last saw h— alive on Jan 31 1945.

	DURATION
Immediate cause of death: Pulmonary Edema	24 hrs.
Due to: Cerebral Arteriosclerosis	8 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. G. H. Hoffman M. D. or other

Address: 2/2/45, Smithsburg, Md. Date Signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53-2 1 1

CERTIFICATE OF DEATH

00918

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington Co. Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 weeks

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Knoxville P.O. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edward Ashby Olden

3. (b) Social Security Number 214-14-6481

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Hallie E. Olden

6(c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) May 5, 1913

8. AGE: Years	Months	Days	If less than one day
31	8	14	hrs. min.

9. Birthplace Harpers Ferry, W. Va.

(Town, county, and state)

10. Usual occupation employed of B. & O. R. R. (fireman)

11. Industry or business

FATHER 12. Name Jacob Olden

13. Birthplace Taneytown, Md.

MOTHER 14. Maiden name Mary E. Frederick

15. Birthplace Knoxville, Md.

16. Informant Mary E. Olden

Address Knoxville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 22, 1945 (month) (day) (year)

Cemetery or crematory Brethren Cemetery

Location Brownsville, Md.

16. Funeral director Gladhill Co.

Address Middletown, Md.

19. Jan 22 1945 (Date rec'd by registrar) Chas. H. Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19, 1945, at 6.29 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1945, to January 19, 1945, and that I last saw h-- alive on January 19, 1945.

Immediate cause of death	DURATION
Lymphosarcoma	3-4 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations Enlarged inguinal nodes

Massive oedema.

Of autopsy Same

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Peregrine Tervoll Jr. M. D. or other

Address Hagerstown, Md. Date signed 1/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-(2)

00919

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:

County: Washington

City or town: Rural-Harpers Ferry, R.R.# 1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Rural Harpers Ferry, R.R.# 1
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Albert Ross Peacher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Wilhemina Peacher

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 13 1855

8. AGE: Years	Months	Days	If less than one day
89	4	23	..... hrs. ..... min.

9. Birthplace: Wash, Co, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: John Peacher
13. Birthplace: Wash, Co, Md.

MOTHER
14. Maiden name: Not Known
15. Birthplace: Not Known

16. Informant: Mrs Russell Miller
Address: Harpers Ferry, R.R.# 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 8 1945 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Samplesmanor, Md.

18. Funeral director: J.H. Castles.

Address: Bolivar, W.Va.

19. Jan 6 1945 (Date rec'd by registrar) Dorothea H. Castle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 5 1945 at 3:10P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Jan 5 1945 and that I last saw h.. alive on Jan 5 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Dec 1-44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William Shumaker M.D., other

Address: Burnsville R Date signed: Jan 6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-P)

00920

CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH:
County: Washington
City or town: Keedysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Keedysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Catherine Potter

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George W. Potter
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 18, 1863

8. AGE: Years	Months	Days	If less than one day
81	9	2	hrs. min.

9. Birthplace: Frederick County, Md. (Town, county, and state)
10. Usual occupation: House-wife
11. Industry or business

FATHER
12. Name: B. F. Edmonds
13. Birthplace: Fred. County, Md.

MOTHER
14. Maiden name: Elizebth Koontz
15. Birthplace: Fred. County, Md.

16. Informant: Mrs. Harry Eckman
Address: Keedysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23, 1945 (month) (day) (year)
Cemetery or crematory: Fair-view
Location: Keedysville, Md.

18. Funeral director: R. I. Earnshaw
Address: Keedysville, Md.

19. Jan 22nd 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 20 19 45 at 11:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 22 19 44, to Jan 20 19 45, and that I last saw her alive on Jan 20 19 45.

Immediate cause of death	DURATION
Cerebral Thrombosis.	2 months.
Due to: General Arteriosclerosis	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Walter D. Sheafer M.D.
M. D. or other
Address: Sharpsburg, Md. Date signed Jan 22, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00921

Reg. Diat. No. 302

1. PLACE OF DEATH

County Washington

City or town Near Hagerstown

(If outside city or towo limits, write RURAL and give nearest towo)

How long in above place of death? 2 years.

Hospital, Institution, or street address where death occurred: Preston Road, Fountain Head Hts.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Near Hagerstown Md.

(If ontside city or town limits, write RURAL and give nearest town)

Street No. Preston Road, Fountain Head Hts.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Philip Sheridan Reel

3.(b) Social Security Number 215-20-9947

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Sarah Reel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November - 1 - 1871

8. AGE: Years	Months	Days	If less than one day
73	2	26	..... hrs. ..... min.

9. Birthplace Keedysville Washington Co. Md.
(Towo, conoty, and state)

10. Usual occupation Harness Maker

11. Industry or business own shop.

FATHER 12. Name Jacob Reel

FATHER 13. Birthplace Keedysville Washington Co. Md

MOTHER 14. Maiden name Anna C. Keefer

MOTHER 15. Birthplace Keedysville Washington Co. Md

16. Informant Mrs. Rowland Morgan

Address Preston Road, Hagerstown Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 31 1945 (month) (day) (year)

Cemetery or crematory Zouriers Cemetery

Location Keedysville Md.

18. Funeral director Wm J. Bart & Sons

Address Boonsboro Md.

19. Jan. 30 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 27 1945 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Incinde pregoancy within 3 mooths of death)

Major findings of operations No

Date of op. .....

Aotopsy results No

PHYSICIAN: Please uoderline the canse to which death shoold be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followiog:

Accident, suicide, or homicide No Date of .....

Where did injury occur? ..... (City or town) (Conoty) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Deputy Med. Exam. L. Robert Wells Wash. Co. Md. M. D.

Address Hagerstown Md. Date signed 1-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

00922

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH:
County Washington
City or town Rural - Keedysville -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Rural - Keedysville -
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mt. Briar
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Infant Rice.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21 1945

8. AGE: Years | Months | Days | If less than one day 17 hrs. min.

9. Birthplace Keedysville, Washington, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Russell David Rice
13. Birthplace Washington Co.

MOTHER 14. Maiden name Bertha Florence Ferguson
15. Birthplace Washington Co.

16. Informant Bertha Florence Ferguson
Address Keedysville

17. (Burial, cremation, or removal. Which?) Date thereof January 23 1945 (month) (day) (year)

Cemetery or crematory Cemetery
Location Keedysville Md

18. Funeral director Russell David Rice
Address R.F.D. Keedysville Maryland

19. Jan 22 1945 Mrs. Katharine Lagenhaft - Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1945, at 7 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 21 1945 to Jan. 22 1945 and that I last saw h.e alive on Jan. 21 1945

Immediate cause of death	DURATION
Premature - Imm.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. W. Leland M.D.
M. D. or other
Address Boonsboro, Md Date signed Jan 23, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

00923

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:

County: Washington

City or town: near Sharpsburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One year.

Hospital, Institution, or street address where death occurred: Keedysville Md. R. 1.

How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: near Sharpsburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Keedysville Md. R. 1

(If rural, give LOCATION)

2.(a) If veteran, name war: None.

3.(a) FULL NAME: John N. Ritter

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Emma Ritter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 5. 1862

8. AGE: Years	Months	Days	If less than one day
82	10	23	..... hrs. ..... min.

9. Birthplace: Waynesboro Penna (Town, county, and state)

10. Usual occupation: Black Smith

11. Industry or business:

FATHER — 12. Name: Jacob Ritter

13. Birthplace: Germany

MOTHER — 14. Maiden name: no Record

15. Birthplace: Germany

16. Informant: Ralph Ritter

Address: Funkstown Md

17. Burial - (Burial, cremation, or removal. Which?) Date thereof: Jany. 30. 1945 (month) (day) (year)

Cemetery or crematory: Green Hill Cemetery

Location: Waynesboro Penna

18. Funeral director: Wm. J. Bart & Sons

Address: Boonsboro Md.

19. Jan 29. 1945 (Date rec'd by registrar) Earl Rogers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1945 to ..... 19..... and that I last saw h.... alive on Jan 28 1945.

Immediate cause of death	DURATION
Cardio-Vascular-Renal disease	9 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Walter H. Shealy M.D. M. D. or other

Address: Sharpsburg Md Date signed: 1/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00924

CERTIFICATE OF DEATH

Reg. Dist. No. 30-

1. PLACE OF DEATH:

County: Washington (WITHIN CORPORATE LIMITS)

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

32 Summit Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown (WITHIN CORPORATE LIMITS)

(If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Summit Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Frank W. Sacwright

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ivy E. Sacwright

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1879

8. AGE: Years	Months	Days	If less than one day
65	3	4	..... hrs. ..... min.

9. Birthplace: Bucks Valley - Pennsylvania (Town, county, and state)

10. Usual occupation: Restaurant Prop.

11. Industry or business

FATHER — 12. Name: John Sacwright

FATHER — 13. Birthplace: ---------- Penn.

MOTHER — 14. Maiden name: Sarah C. Depew

MOTHER — 15. Birthplace: ---------- Penn.

16. Informant: Mrs. Ivy E. Sacwright

Address: 32 Summit Ave. - Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29-45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Jan 29 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 26, 1945 4:00 A.M. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 1945 to Jan 26 1945 and that I last saw h.. alive on Jan 25 1945

Immediate cause of death	DURATION
Cerebro-sclerosis	
Heart Disease	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Sidney Hoverter M.D. (M. D. or other)

Address: Funkstown Md Date signed 1/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00925

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-9 D

CERTIFICATE OF DEATH

Reg. Dist. No. 30 2

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46
Hospital, institution, or street address where death occurred:
44 Wayside Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 44 Wayside Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter L. Campbell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Carrie B. Campbell
6.(c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) Oct 29-1863

8. AGE: Years	Months	Days	If less than one day
81	2	2	hrs. min.

9. Birthplace Middleburg Pa
(Town, county, and state)
10. Usual occupation Hedge trimmer
11. Industry or business Retired
FATHER 12. Name Henry G. Campbell
13. Birthplace Germany
MOTHER 14. Maiden name Lucinda Redmond
15. Birthplace Middleburg Pa
16. Informant Joseph B. Campbell
Address Annapolis Md
17. Burial Date thereof Jan 4-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rest Haven
Location Hagerstown Md
18. Funeral director Scott F. Minnick Son
Address Hagerstown Md
19. Jan. 3. 1945 Chas H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1945, at 4 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31- 1944, to Jan 1 1945
and that I last saw h-- alive on Jan 1 1945

Immediate cause of death Carcinoma of Pancreas. — DURATION July 1944

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Sidney Rowerstein M.D.
M. D. or other
Address Funkstown Md Date signed 1/1/45

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00926

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:

629 Pennsylvania Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: WITHIN CORPORATE LIMITS

(If outside city or town limits, write RURAL and give nearest town)

Street No. 629 Pennsylvania Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Harris Schaff

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah I. Schaff

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1868

8. AGE: Years	Months	Days	If less than one day
76	2	5	hrs. min.

9. Birthplace: Browns Mills- Franklin- Pa.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Jaremiah Schaff

13. Birthplace: Franklin Co. , Pa.

MOTHER — 14. Maiden name: Margaret Gearhart

15. Birthplace: Franklin Co., Pa.

16. Informant: Mrs. Sarah I. Schaff

Address: 629 Penn. Avenue- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 17-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Jan 16. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 14, 1945 19 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 7 19 45 to Jan 14 19 45

and that I last saw him alive on Jan. 9th 19 45

Immediate cause of death: Cerebral Thrombosis — DURATION: 1 week

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank F. Shupp, M.D. M. D. or other

Address: 109½ N. Potomac St Hagerstown Maryland Date signed: Jan 15 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Schnebley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-a

CERTIFICATE OF DEATH

00927

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington
City or town Williamsmsport Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 E. Potomac
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Kate Lee Schnebly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 9 1869

8. AGE: Years	Months	Days	If less than one day
75	4	12	..... hrs. ..... min.

9. Birthplace Williamsport Md (Town, county, and state)
10. Usual occupation Retired School Teacher
11. Industry or business Public Schools
FATHER 12. Name Albert Schnebley
13. Birthplace Hagerstown Md
MOTHER 14. Maiden name Kate Hollman
15. Birthplace Williamsport Md.
16. Informant Mrs Edith Schnebley
Address 947 Mulberry Hagerstown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 24 1945 (month) (day) (year)
Cemetery or crematory Riverview Cem
Location Williamsport Md
18. Funeral director Edith V. Leaf
Address Williamsport Md

19 Jan 28 1946 (Date rec'd by registrar) Mrs Ea Lee McEbley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1945, at 7 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1944, to Jan. 20 1945 and that I last saw h-- alive on Jan. 20 1945

	DURATION
Immediate cause of death Cerebral Hemmorhage	30 days
Due to Arteria Sclerosis.	2 Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Williamsport Md Date signed 1/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

00928

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:
County: Washington
City or town: Smithsburg # 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Washington
City or town: Smithsburg # 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph L Shelby

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 2 1868

8. AGE: Years	Months	Days	If less than one day
76	7	17	..... hrs. ..... min.

9. Birthplace: Ringgold Md (Town, county, and state)
10. Usual occupation: Millwright
11. Industry or business
FATHER 12. Name: Abram Shelby
FATHER 13. Birthplace: Ringgold Md
MOTHER 14. Maiden name: Catherine Kohler
MOTHER 15. Birthplace: Md
16. Informant: Mrs G. W. Shelby
Address: Smithsburg Md # 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 22 1945 (month) (day) (year)
Cemetery or crematory: Stouffers Cemetery
Location: Near Smithsburg Md
18. Funeral director: Walter G. Grove
Address: Waynesboro Pa
19. Jan 20 1945 (Date rec'd by registrar) Geo W Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19 1945, at 3.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1945 to Jan 19 1945 and that I last saw h... alive on Jan 19 1945

	DURATION
Immediate cause of death: Coronary Occlusion	2 hrs.
Due to: Cerebro Sclerosis	10 yrs.
Due to: General Dropsy	
Due to:	
Other conditions: Bronchitis Asthma	30 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. C. Kohler M.D. (M. D. or other)
Address: Smithsburg Md Date signed: 1/20/45

M

I MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-d) X

00929

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

134 Winter Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 134 Winter Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Roy M. Shetron

3. (b) Social Security Number 204-01-9389

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary E. Shetron

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 7, 1888

8. AGE: Years	Months	Days	If less than one day
56	7	21	..... hrs. ..... min.

9. Birthplace Edenville- Franklin Co., Pa.
(Town, county, and state)

10. Usual occupation Factory Worker

11. Industry or business

FATHER

12. Name Jacob Shetron

13. Birthplace Franklin Co., Pa.

MOTHER

14. Maiden name Ella Taylor

15. Birthplace Franklin Co., Pa.

16. Informant Mrs. Mary E. Shetron

Address 134 Winter Street-Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31-45 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. Jan. 31, 1945 (Date rec'd by registrar) L. Scott Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28-45 12:45 [illegible] M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 19 45 to Jan 28 19 45

and that I last saw h[illegible] alive on Jan 28 19 45

Immediate cause of death Carcinoma of Cervix

DURATION 1 yr

Due to

Due to

Other conditions Cellulitis of Abdomen Metastasis to Abdomen

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Bucell M. D.

Address Hagerstown, Md. Date signed Jan 28 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

00930

CERTIFICATE OF DEATH

Reg. Diat. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

1030 Kuhn Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1030 Kuhn Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Edith I. Shipley

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Kuhn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 4, 1875

8. AGE:

Years	Months	Days	If less than one day
70	0	14	..... hrs. ..... min.

9. Birthplace: Elkton, Virginia (Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER

12. Name: William Shipley

13. Birthplace: ---------- Virginia

MOTHER

14. Maiden name: Mary A. Kane

15. Birthplace: ---------- Virginia

16. Informant: Mrs. Segerna E. Kelly

Address: 1030 Kuhn Avenue - Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 20-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Jan 20 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 17, 1945 9:15 A. M. (or P. M.)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17 1944 to Jan 17 1945

and that I last saw h[illegible] alive on Jan 17 1945

	DURATION
Immediate cause of death: Coronary Occlusion	Immediate
Due to: Arteriosclerotic Hypertensive Cardio Vascular Disease	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ralph F. Young M. D. or other

Address: Williamsport, Md. Date signed: 1-18-45

STATE OF MARYLAND—CERTIFICATE OF DEATH

00931

1. PLACE OF DEATH

County Washington — Registration Dist. No. 303

Village or City Hagerstown. — No. Washington County Hosp. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 7 ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Baby Boy Shoemaker — If U. S. Veteran, specify WAR ____

(a) Residence: No. Clearspring Md. St., Ward. (Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M.	W.	Single

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of ____

6. DATE OF BIRTH (month, day, and year) Dec. 29. 1944

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
			7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None.

9. Industry or business in which work wes done, as SILK MILL, SAW MILL, BANK, etc. ____

10. Date deceased last worked at this occupation (month and year) ____ — 11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) Clearspring. Md. (State or country)

FATHER

13. NAME Jess Lester Shoemaker

14. BIRTHPLACE (city or town) Millstone (State or country) Maryland.

MOTHER

15. MAIDEN NAME Dorothy Mummart

16. BIRTHPLACE (city or town) Big Pool (State or country) Maryland

17. INFORMANT Jess L. Shoemaker (Address) Clearspring Md.

18. BURIAL, CREMATION, OR REMOVAL Place St Pauls Cemetery Burial Date Jan. 8, 1945

19. UNDERTAKER Snyder—Rowland (Address) Clear Spring Md

20. FILED Jan 8, 1945 Joseph W. Murray Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January (Month) 6 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1944, to Jan 6, 1945

I last saw him alive on Jan 5, 1945; death is said to have occurred on the date steted above, at 1:35 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Congenital Anomalies—	
1. Imperforate anus—	Birth
2. S Fistulae rectum	"
3. Hypospadius. Aerese	"
4. Congenital absence Rt. Ear	"
5. Underdeveloped lower extremities	

Other Contributory Causes of importance:

Name of operation None. Date of ____

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or Injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) Carlos Roberts Cohen M. D.

(Address) Clearspring Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Dr. porterfield
00932

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74-a

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Chewsiville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
Chewsville - Smithsburg Road
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Chewsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chewsville-Smithsburg Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Howard Rector Sinsel

3.(b) Social Security Number: 235-03-6352

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): December 13 1888

8. AGE: Years	Months	Days	If less than one day
56	1	2	...hrs. ...min.

9. Birthplace: Grafton Taylor Co. W.Va. (Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Grocery store
FATHER 12. Name: Winfield Sinsel
13. Birthplace: Grafton W.Va.
MOTHER 14. Maiden name: Julia Ann Rector
15. Birthplace: Grafton W.Va.
16. Informant: Mrs. Anna D. Sinsel
Address: Chewsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/17/45 (month) (day) (year)
Cemetery or crematory: River View Cemetery
Location: Williamsport Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. Jan. 16. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1945 at 1.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1945 to Jan 15 1945 and that I last saw him alive on Jan 15 1945

Immediate cause of death	DURATION
Coronary occlusion	1/15/45
Due to: Arteriosclerosis	?
Due to: Hypertension	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.: ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of: ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ...
Means of injury: ... Injured at work?

23. SIGNATURE: H.S. Porterfield M.D. (M. D. or other)
Address: 136 W Washington Date signed: 1/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of cause of death is shown on FILM No. G 9 4 APR 7 1945

00933

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 weeks.

Hospital, Institution, or street address where death occurred: Wash. Co. Hospital

How long in hospital or institution? 20 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.: N. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Flora Cornelia Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles E. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 20 1872

8. AGE:

Years	Months	Days	If less than one day
72	4	18	..... hrs. ..... min.

9. Birthplace: Boonsboro Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Own Home

FATHER
12. Name: John Bowman
13. Birthplace: Beaverdam Wash. Co. Md.

MOTHER
14. Maiden name: Margaret Stouffer
15. Birthplace: near Hagerstown Wash. Co. Md.

16. Informant: Mr. Evan B. Smith

Address: Boonsboro Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof January 12 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetery

Location: Boonsboro Md.

18. Funeral director: Wm. D. Bast & Sons

Address: Boonsboro Md.

19. Jan. 10 1945 (Date rec'd by registrar) Chas. H. Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8 1945 at 11.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 1944 to January 8 1945 and that I last saw h.. alive on January 8 1945

Immediate cause of death	DURATION
Chronic myocarditis	5 yrs.
Due to Fracture of left hip	4 mos.
Accidental fall, was walking in her yard. C.W.&R.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of October 15, 1944

Where did injury occur? Boonsboro (City or town) Washington (County) Maryland (State)

Injured at home, farm, industry, public place (where?): At her home

Means of injury: ..... Injured at work? .....

23. SIGNATURE: G. W. LeVan M. D.

M. D. or other

Address: Boonsboro Date signed: 1/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of birth date of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-d

00934

FILM No. G 92 MAR 10 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

119 High Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 119 High Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Harry A. Snyder

3. (b) Social Security Number: 214-09-8617

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eva J. Snyder

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 11, ~~1885~~ 1875

8. AGE:	Years	Months	Days	If less than one day
	69	1	8	hrs. min.

9. Birthplace: Mason and Dixon- Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation: Hardware Store employee

11. Industry or business

FATHER
12. Name: Emanuel Snyder
13. Birthplace: Franklin Co., Pa.

MOTHER
14. Maiden name: Emma Harnish
15. Birthplace: Franklin Co., Pa.

16. Informant: Mrs. Eva J. Snyder-
Address: 119 High Street- Hagerstown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 22-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Jan. 20, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 19, 1945 at 2:45 a.m. p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 19 44 to Jan 19 19 45 and that I last saw h. alive on Jan 18 19 45

Immediate cause of death	DURATION
Chronic Endocarditis	(?)
auric. & Mitrosis	
Due to: Pa	
Due to:	
Other conditions: 0	

(Include pregnancy within 3 months of death)

Major findings of operations: 0

Date of op.

Autopsy results: 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: 0 Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Victor D. Miller

23. SIGNATURE: DR. VICTOR D. MILLER M. D. or other

Address: 131 W. WASHINGTON, ST. Date signed: 1/19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

Dr. Ditto
00935
Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
Mennonite Home
How long in hospital or institution? 5 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mennonite Home
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Jacob A. Snyder

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 25 1864

8. AGE: Years	Months	Days	If less than one day
80	9	17	..... hrs. ..... min.

9. Birthplace: Millstone Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: Henry Snyder
13. Birthplace: Millstone Md.

MOTHER
14. Maiden name: Lizzie Martin
15. Birthplace: Millstone Md.

18. Informant: Phares Horst
Address: Paramount Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/45 (month) (day) (year)
Cemetery or crematory: Mennonite Cemetery
Location: near Clearspring Md.

18. Funeral director: A. Eugene Minnich
Address: Greencastle Pa.

19. Jan. 13, 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1945, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-1-44 19.. to 1-12-45 19.. and that I last saw him alive on 1-12-45 19..

Immediate cause of death	DURATION
Due to: Che Myocarditis	6 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: I W Ditto M. D. or other
Address: Hagerstown Md. Date signed: 1/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

Dr. Prather

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

00936

Reg. Dist. No. 302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Washington (WITHIN CORPORATE LIMITS)

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Mos.

Hospital, institution, or street address where death occurred:

816 Summit Ave

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington (WITHIN CORPORATE LIMITS)

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 816 Summit Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: William Newton Spessard

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nettie M.

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): September 4 1874

8. AGE: Years	Months	Days	If less than one day
70	4	26	....hrs. ....min.

9. Birthplace: Chewsville Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business: Retired

FATHER

12. Name: David C. Spessard

13. Birthplace: Chewsville Md.

MOTHER

14. Maiden name: Mary E. Zentmyer

15. Birthplace: Chewsville Md.

16. Informant: Mrs. Nettie M. Spessard

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/1/45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Feb. 1. 1945 (Date rec'd by registrar) Chas. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 1945 19.... at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1944 to Jan. 30 1945

and that I last saw him alive on Jan. 30 1945

Immediate cause of death	DURATION
Cerebral hemorrhage.	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) .... (County) .... (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: B. Prather M. D. or other

Address: Hagerstown Md. Date signed 1/31/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94-a

CERTIFICATE OF DEATH

Dr. Kneisley

00937

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington

City or town Hagerstwon (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, institution, or street address where death occurred: 811 The Terrace

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstwon (If outside city or town limits, write RURAL and give nearest town)

Street No. 811 The Terrace (If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Miss Mildred Phyllis Stine

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife -

6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) March 15 1919

8. AGE: Years	Months	Days	If less than one day
25	10	-	...hrs. ...min.

9. Birthplace Hagerstown Wash. Co. Md. (Town, county, and state)

10. Usual occupation unemployed

11. Industry or business at home

FATHER 12. Name Victor F. Stine

13. Birthplace Hagerstown Md.

MOTHER 14. Maiden name Ruth Middlekauff

15. Birthplace Hagerstown Md.

16. Informant Victor F. Stine

Address Hagerstwon Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/17/45 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstwon Md.

18. Funeral director Andrew K. Coffman

Address Hagerstwon Md.

19. Jan 15, 45 (Date rec'd by registrar) Chas H Brewer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1945 19... at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9 1945 to Jan. 15 1945 and that I last saw her alive on January 14, 1945 19...

Immediate cause of death	DURATION
Coronary occlusion	1/2 hr
Other conditions:	
Chronic ureteral stricture	3 yrs
Arrested mental development since birth (probably cerebral birth injury)	since birth

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE B B Kneisley M. D. or other

Address 148 W. Washington St. Date signed 1/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25-C)

00938

CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH:
County: Washington
City or town: Keedysville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 76 Madison Ave,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles E. Stoneberger

3.(b) Social Security Number: 220- 10- 3693

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 27, 1884

8. AGE: Years	Months	Days	If less than one day
60	0	14	hrs. min.

9. Birthplace: Page Co. Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Lewis Stoneberger
13. Birthplace: Luray, Virginia

MOTHER
14. Maiden name: Katherine Campbell
15. Birthplace: Luray, Virginia

18. Informant: Mrs. Beatrice V. Simmers
Address: Keedysville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 13 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Hagerstown, Md.
18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Jan. 10. 1945 (Date rec'd by registrar) R. A. Keeting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1945 at 7.15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 9 1945 to Jan 9 1945 and that I last saw him alive on Jan 9 1945

Immediate cause of death	DURATION
Acute dilation of right ventricle of heart	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. W. Leiby M. D.
M. D. or other
Address: Boonsboro, Md. Date signed: 1/10/45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00939

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred: Washington Co. Hospital

How long in hospital or institution? 6 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 Dennis ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Stoner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE:

Years	Months	Days	If less than one day
30 1914	Feb 28		1914 hrs. min.

9. Birthplace: Mercersburg

(Town, county, and state)

10. Usual occupation: House work

11. Industry or business:

FATHER

12. Name: James H. Stoner

13. Birthplace: Mercersburg

MOTHER

14. Maiden name: Jessie M. Duff

15. Birthplace: Fayetteville Co Pa

16. Informant: John Stoner

Address: 619 Dennis ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31 45 (month) (day) (year)

Cemetery or crematory: Rosehill Cemetery

Location: Hagerstown

18. Funeral director: William H Downey

Address: 291 Frederick St

19. Jan 31 1945 (Date rec'd by registrar) Chas H Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 28 1945, at 3.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 11 1944, to Jany 28 1945 and that I last saw her alive on Oct 11 1945 1944

Immediate cause of death	DURATION
Congestive Heart Failure	4 Months
Due to	
Due to	
Other conditions: Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. D. Campbell M. D. or other

Address: Hagerstown Md Date signed 1-30-45

00940

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred: 1015 Oak Hill Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1015 Oak Hill Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Zeller Storey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 7, 1864

8. AGE: Years	Months	Days	If less than one day
81	0	1	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation Retired Bookkeeper

11. Industry or business

FATHER

12. Name John W. Storey

13. Birthplace Laurel, Maryland

MOTHER

14. Maiden name Sallie Stover

15. Birthplace Hagerstown, Maryland

18. Informant Mrs. W. B. Littleton

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-10-44 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Jan 9 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 1945, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1943, to Jan 7 1945 and that I last saw h.er alive on Jan 7 1945

Immediate cause of death	DURATION
Respiratory failure	
Due to Cerebral hemorrhage.	
Due to arterio-sclerosis	
Other conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Lee Lemmon M.D. M. D. or other

Address Hagerstown, Md. Date signed 1-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00941

Reg. Dist. No. 30 2

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1 Hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1026 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Opal M. Turner.

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femmale	White	Married

6.(b) Name of husband or wife: Marvin Turner

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 17, 1906

8. AGE: Years	Months	Days	If less than one day
38	10	14	..... hrs. ..... min.

9. Birthplace: Emmitsburg Md (Town, county, and state)

10. Usual occupation: Home work

11. Industry or business:

FATHER — 12. Name: Elijah Baker

FATHER — 13. Birthplace: Frederick County, Md.

MOTHER — 14. Maiden name: Fannie Eyler

MOTHER — 15. Birthplace: Frederick County, Md.

16. Informant: Mrs. Jean Myers

Address: 1026 Penn. Ave. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 3-1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Feb. 1. 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31, 1945 at 1:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/10 19 43, to 1/31 19 45 and that I last saw h. alive on 1/31/45 19.....

	DURATION
Immediate cause of death: Cerebral hemorrhage	3 hours.
Due to: Hypertensive cardio vascular disease	8 years (?)
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John N Hornbaker M. D. M. D. or other

Address: 154 W. Washington St. Date signed 1/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Lathan

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

00942 316.

Reg. Dist. No. 209

1. PLACE OF DEATH:
County Washington
City or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years.
Hospital, Institution, or street address where death occurred:
Keedysville Md.
How long in hospital or institution? At Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Keedysville.
(If ontside city or town limits, write RURAL and give nearest town)
Street No. Keedysville Md.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME William Clayton Weaver

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Cora Long Weaver
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April - 9 - 1878

8. AGE: Years	Months	Days	If less than one day
66	9	0	..... hrs. ..... min.

9. Birthplace Clearspring Washington Co. Md.
(Town, county, and state)
10. Usual occupation Farmer.
11. Industry or business Retired
FATHER 12. Name W. D. Weaver.
13. Birthplace Virginia
MOTHER 14. Maiden name Catherine Baylor.
15. Birthplace Pennsylvania
18. Informant Mrs. Cora Weaver
Address Keedysville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany. 13. 1945 (month) (day) (year)
Cemetery or crematory Dunkers Cemetary
Location Keedysville Md.
18. Funeral director Wm. D. Bast & Sons
Address Boonsboro Md
19. Jan 11 1945 (Date rec'd by registrar) J. P. Keefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1945, at 9 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 1943, to to Jan. 9 1945 and that I last saw him alive on January 2 1945
Immediate cause of death ..... DURATION
Angina Pectoris.
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)
Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE G. W. Lathan M. D.
M. D. or other
Address Boonsboro Md Date signed 1/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Yeagee

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 00943 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Years

Hospital, institution, or street address where death occurred:

37 Coffman Ave

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 37 Coffman Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Lottie Edith Wilkes

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Clarence V.

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): May 30 1884

8. AGE: Years	Months	Days	If less than one day
60	7	2	...hrs. ...min.

9. Birthplace: Detour Carroll Co Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Thomas Kemp
13. Birthplace: Taneytown Md.

MOTHER
14. Maiden name: Julia Eyler
15. Birthplace: Detour Md.

16. Informant: Clarence V. Wilkes
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/5/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Jan. 4 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1, 1944, to Jan. 2 1945, and that I last saw h... alive on Jan. 2 1945

Immediate cause of death	DURATION
Diabetes Mellitus	10 yrs
Diabetic coma	48 hrs
Due to Coronary Thrombosis	10-10-44
Due to Arteriosclerosis	10 yrs.
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W Howard Yeagee, M. D. or other

Address: Hagerstown Md. Date signed 1-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Yeager

00944

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Days
Hospital, Institution, or street address where death occurred: Washington Co. Hospital
How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Funkstown, Hill
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: David Horald Winger

3. (b) Social Security Number: 214-05-8748

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): September 27, 1909

8. AGE: Years	Months	Days	If less than one day
~~35~~ 35	3	26	..... hrs. ..... min.

9. Birthplace: Welsh Run Franklin Co. Penna.
(Town, county, and state)

10. Usual occupation:
11. Industry or business: Fairchilds

FATHER
12. Name: Clyde E. Winger
13. Birthplace: Welsh Run? Penna.

MOTHER
14. Maiden name: Annie. M. Angle
15. Birthplace: Welsh Run, Penna.

16. Informant: Mrs Helen Winger
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 25, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Maryland

18. Funeral director: Andrew K. Coffman
Address: Hagerstown, Maryland.

19. Jan 23 1945 (Date rec'd by registrar) C. Kraft Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23, 1945 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27, 1944, to Jan. 23, 1945, and that I last saw h~~im~~er alive on Jan. 23, 1945

Immediate cause of death	DURATION
Carcinoma Breast	1 month
Due to: Carcinoma of Rt. breast	aug. 1944
Due to: Malignant Carcinoma Rt. breast	
Other conditions: Removal of Rt. breast	1943

(Include pregnancy within 3 months of death)

Major findings of operations: Removal Rt. breast Carcinoma Malignant Date of op. 1943.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W Horald Yeager M. D. or other
Address: Hagerstown, Md Date signed: 1-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

00945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 Yr
Hospital, Institution, or street address where death occurred: Randolph Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Washington
WITHIN CORPORATE LIMITS
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)
Street No. Randolph Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John S Walfe

3.(b) Social Security Number 218-24-1215

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife Ellen Gountie
6.(c) If alive, give age 78 years
7. Birth date of deceased (mo., day, yr.) Jan 2 1861

8. AGE:

Years	Months	Days	If less than one day
84	0	26	...hrs. ...min.

9. Birthplace Washington Co. Md. (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business

FATHER
12. Name Daniel Walfe
13. Birthplace Washington Co. Md.

MOTHER
14. Maiden name Emma Marian Rowland
15. Birthplace Washington Co. Md.

16. Informant Mrs John S Walfe
Address Randolph Ave Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 1 1945 (month) (day) (year)
Cemetery or crematory Manor Cemetery
Location Manor

18. Funeral director William H Downey
Address 291 Frederick St Hagerstown

19. Feb 1 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1945 at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/23 1945 to 1/30 1945
and that I last saw h. alive on 1/29 1945

Immediate cause of death	DURATION
Chronic Endocarditis	(?)
arterio-sclerosis	
Due to	
Due to	
Other conditions ✓	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Victor D Miller
DR. VICTOR D. MILLER M. D. or other
Address 131 W. WASHINGTON, ST. Date signed 1/30 1945
HAGERSTOWN, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00946

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County (OUTSIDE CORPORATE LIMITS) Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town (OUTSIDE CORPORATE LIMITS) Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 145 South Prospect Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Eugenia Lane Wroth

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1854

8. AGE: Years	Months	Days	If less than one day
90	3	25	..... hrs. ..... min.

9. Birthplace Kent County, Maryland (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Thomas G. Wroth

13. Birthplace Kent County, Maryland

MOTHER 14. Maiden name Mary E. Wroth

15. Birthplace Kent County, Maryland

16. Informant Dr. Peregrine Wroth

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-6-45 (month) (day) (year)

Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Jan. 5. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1945, at 12.20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1944, to Jan 4 1945

and that I last saw h... alive on Jan. 3 1945

Immediate cause of death	DURATION
Lobar Pneumonia	6 days
Due to	
Due to	
Other conditions Acute Cardiac Failure (Include pregnancy within 3 months of death)	1 day

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE O H Binkley M.D M. D. or other

Address Hagerstown Md Date signed 1/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-L)

CERTIFICATE OF DEATH

01947

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstwon
(If ontside city or town limits, write RURAL and give nearest town)
How tong in above place of death? 8 Days
Hospital, institution, or street address where death occurred:
53 Harmans Alley
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W. Va. County Berkley
City or town Martinsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 Eulalia St.
(If rural, give LOCATION)
2.(a) If veteran, name war None ✓

3. (a) FULL NAME John Henry Zepp

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Katherine
6.(c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) March 8 1872

8. AGE: Years	Months	Days	If less than one day
72	10	14	...hrs. ...min.

9. Birthplace Martinsburg Berkley Co. W. Va.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business ---
FATHER 12. Name George Zepp
13. Birthplace Martinsburg W. Va.
MOTHER 14. Maiden name No Record
15. Birthplace No Record
16. Informaot John Zepp
Address Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/25/45 (month) (day) (year)
Cemetery or crematory Bellvieu cemetery
Location Hagerstown Md.
18. Funeral director Andrew K. Coffman
Address Hagerstwon Md.
19. Jan 25 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1945 at 11.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I atteeded deceased from Jan. 18 1945, to Jan. 23 1945
and that I last saw him alive on Jan. 22 1945

	DURATION
Immediate cause of death Cerebral Thrombosis	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Frank F. Shupp M.D. M. D. or other
Address 109½ N. Potomac St Hagerstown Maryland Date signed Jan 24 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15